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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by physicians and osteopaths as deemed appropriate by Medicaid. It addresses the following:

- General physician/osteopath policy
- Medical policy restrictions
- Medical/surgical review
- Specific medical services
- Prior authorization
- Claims billing

3.1.2 Reimbursement

Medicaid reimburses physician/osteopath services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. Physician/osteopath services must be billed by the physician/osteopath provider electronically or on the CMS 1500 claim form using the appropriate CPT procedure codes.

Idaho Medicaid will reimburse the lowest of the following rates:

- Provider's actual charge for the service.
- Medicaid's established maximum allowable reimbursement from its pricing file for the service.
- Reimbursement for Medicare crossover claims is based on the Medicaid allowed amount and will be the lower of the Medicare allowed amount, the Medicaid allowed amount, or the billed amount.

Check eligibility to see if the client is enrolled in Healthy Connections, Idaho's Medicaid care management program. If a client is enrolled, a referral from the client's primary care physician must be obtained prior to rendering services.

Some surgery and medical procedures are performed at facilities, such as hospitals or surgery centers, and the facility is paid a fee by Medicaid. For those procedures there is an average of 30% reduction in physician reimbursement that is considered a site-of-service differential.

3.1.3 Procedure Codes

Idaho Medicaid follows national procedure codes as listed in the most current version of:

- Current Procedural Terminology (CPT)
- HCPCS

If a non-specific CPT code is used and the Medicaid medical consultant determines a listed CPT code exists that accurately describes the procedure performed, the claim may be denied.

3.1.4 Place of Service Codes

Idaho Medicaid follows national place of service codes. Refer to Current Procedural Terminology (CPT). Enter the appropriate numeric code in the place of service field on the claim.

3.1.5 Physician/Osteopath Service Policy

3.1.5.1 Overview

All physicians/osteopaths, licensed to practice medicine in any U.S. state, are eligible to participate in the Idaho Medicaid Program. They must obtain an Idaho Medicaid provider number from Medicaid prior to submitting claims for services.

See **Section 1.2**, for more on the Idaho Medicaid provider number.

3.1.5.2 Physician/Osteopath Employees

Services provided by employees of a physician/osteopath may not be billed directly to Idaho Medicaid with the exception of psychological testing services provided by a licensed psychologist or social worker. These testing services provided by physician/osteopath employees may be billed under the physician's/osteopath's provider number. This exception applies to testing only.

3.1.5.3 Misrepresentation

Misrepresentation of a physician/osteopath service provided by a non-physician/osteopath professional is prohibited. Those non-physician/osteopath practitioners include, but are not limited to, the following:

- Nurse practitioner
- Registered nurse midwife
- Physical therapist
- Occupational therapist
- Speech therapist
- Psychologist
- Social worker
- Physician assistant

3.1.5.4 Out-of-State Care

Out-of-state providers who are enrolled in the Idaho Medicaid program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid clients without receiving out-of-state prior approval.

All medical care provided outside the State of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho. Refer to **Section 3.3**, Medical/Surgical Review, for more information.

3.1.5.5 Locum Tenens and Reciprocal Billing

Idaho Medicaid allows for physicians to bill for Locum Tenens and Reciprocal Billing.

Definition of Locum Tenens and Reciprocal Billing

The practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as: illness, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physicians services as though he/she performed them.

Duration of Locum Tenens

When the substitute physician covers the regular physician during absences not to exceed a period of 90 continuous days.

Duration of Reciprocal Billing

When the substitute physician covers the regular physician during absences or on an on call basis not to exceed a period of 14 continuous days.

Procedure for Billing

1. The regular physician is unavailable to provide the services.
2. The Medicaid participant has arranged or seeks to receive services from the regular physician.
3. The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.
4. The substitute physician does not provide the services to Medicaid participants over a continuous period of longer than 90 days for Locum Tenens and 14 days for Reciprocal Billing.
5. The regular physician identifies the services as substitute physician services meeting the requirements of this section by appending the appropriate modifier:
 - a. **Q6** (Service furnished by a locum tenens physician) to the end of the procedure code.
 - b. **Q5** (Service furnished by a substitute physician under a reciprocal billing arrangement) to the end of the procedure code.
6. The regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physicians UPIN, and make this record available to the Department upon request.
7. If the only substitution services a physician performs are in connection with an operation and are post-operative services furnished during the period covered by the global fee, those services should not be reported separately on the claim as substitute services.
8. A physician may have locum tenens/reciprocal billing arrangements with more than one physician. The arrangements do not need to be in writing.

3.2 Medical Policy Restrictions

3.2.1 Elective Treatment

Prior authorization is required for all elective (not medically necessary) medical and surgical procedures. Procedures generally accepted by the medical community as medically necessary (Medicaid medical necessity criteria for some procedures are listed in this handbook section) may not require prior authorization and may be eligible for payment.

3.2.2 Injectable Vitamins

Payment for injectable vitamin therapy must be supported by the diagnosis of pernicious anemia. Injectable vitamin therapy is limited to the following:

- Vitamin B₁₂ and its analogues
- Vitamin K and its analogues
- Folic acid
- Vitamin B₁₂ mixtures, folic acid, and iron salts in any combination

3.2.3 Transplants

3.2.3.1 Overview

The Department may purchase organ transplant services for bone marrow, kidneys, hearts, intestines, and livers when provided by hospitals approved by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program and that have completed a provider agreement with the Department. Transplants must be prior authorized by the QIO.

The Department may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. Cornea transplants do not require QIO prior authorization.

3.2.3.2 Heart or Liver Transplants

Heart or liver transplant surgery will be covered only if the procedure is performed in a transplant facility approved for transplant of the heart or liver by Center for Medicare and Medicaid Services (CMS) for the Medicare program and the provider has completed a provider agreement with Medicaid.

3.2.3.3 Kidney Transplants

Kidney transplantation surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one of the End Stage Renal Dialysis (ESRD) network of Health and Human Services for Medicare certification.

3.2.3.4 Living Kidney Donor Costs

The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post operation recovery expenses associated with the donation. Payments

for post operation expenses of a donor will be limited to the period of actual recovery.

3.2.3.5 Coverage Limitations

When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ transplants will not be covered. Under certain conditions, otherwise non-covered transplants may be prior authorized through the EPSDT for children under the age 21.

Each kidney or lung is considered a single organ for transplant.

3.2.3.6 Re-transplants

Re-transplants will be covered only if the original transplant was performed for a covered condition and if the re-transplant is performed in a Medicare/Medicaid approved facility.

3.2.3.7 Multi-organ Transplants

Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered except by prior authorization for an EPSDT client.

3.2.3.8 Transplant Authorization

Except for cornea transplants, all organ transplants are excluded from Medicaid payment unless prior authorized by the Idaho Quality Improvement Organization (QIO) and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy.

3.2.3.9 Noncovered Transplants

Services, supplies, medications, or equipment directly related to a non-covered transplant will be the responsibility of the client.

3.2.3.10 Follow-Up Care

Follow-up care to a client who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation.

3.2.4 Cosmetic Surgery

All surgery which is generally cosmetic in nature is excluded from payment unless it is found to be medically necessary and has Medicaid prior authorization.

3.2.5 Other Noncovered Services

3.2.5.1 Obesity

Surgery for the correction of obesity is covered only with prior authorization from the Bureau of Medicaid Care Management. If approval is given, Qualis Health will issue the authorization number and perform any length of stay review that is necessary. Surgical procedures for weight loss will be considered when the client meets the criteria for morbid obesity as defined in

Rules Governing Medical Assistance, IDAPA 16.03.09.42 and the client has one of the major life threatening complications of obesity, alveolar hypoventilation, uncontrolled diabetes, or uncontrolled hypertension.

For purposes of this subsection, “uncontrolled” means that there is inadequate compliance or response to a prescribed medical regimen. Other complications of obesity such as orthopedic treatment, skin and wound care are not in themselves considered justification for a surgical remedy.

Clients must have a psychiatric evaluation to determine the stability of personality at least three months prior to the date the surgery is requested. The client must understand and accept the resulting risks associated with the surgery.

All clients requesting surgery must have their physician/osteopath send a complete history and physical exam, and medical records documenting the client’s weight and efforts to lose weight by conventional means over the past five years for the request to be considered.

The documentation of life threatening complications (IDAPA 03.09.069.01. a) must be provided by a consultant specializing in pulmonary diseases, endocrinology, or cardiology and hypertensive illness who is not associated by clinic or other affiliation with the surgeons who will perform the surgery, or the primary physician/osteopath who refers the client for the procedure.

Abdominoplasty or panniculectomy is covered only with prior authorization from the Bureau of Care Management. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, the following:

- Photographs of the front, side, and underside of the client’s abdomen
- Documented treatment of the ulceration and skin infections involving the panniculus
- Documented failure of conservative treatment, including weight loss
- Documentation that the panniculus severely inhibits the client’s walking
- Documentation that the client is unable to wear a garment to hold the panniculus up
- Documentation of other detrimental effects of the panniculus on the client’s health such as severe arthritis in the lower body.

3.2.5.2 Unproven/Questionable Procedures

New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare program are excluded from payment by Medicaid.

3.2.5.3 Complications

The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening.

3.2.5.4 Acupuncture

Acupuncture is not covered.

3.2.5.5 Naturopathic Services

Naturopathic services are not covered.

3.2.5.6 Biofeedback Therapy

Biofeedback therapy is not covered.

3.2.5.7 Fertility Related Services

Fertility-related services, including testing, are not covered.

3.2.5.8 Laetrile

Laetrile is not covered.

3.2.5.9 Examinations

Wellness physicals for individuals age twenty-one (21) and older and pre-employment physicals are not a covered Idaho Medicaid service. An exception to this is when the wellness physical examination for an adult is an Idaho Medicaid program requirement. The following two codes are to be used only when an exam and/or report is requested by the Department for an adult client for the purpose of Medicaid program requirements.

When billing for an exam and/or report that has been requested by the Department, report with ICD-9 diagnosis code **V70.3** (*other medical examination for administrative purposes*) as the primary diagnosis code. This includes annual history and physicals (H & P) required for adults residing in an ICF/MR (intermediate care facility/mentally retarded).

- 99450 – Basic Life and/or disability examination that includes: History and Physical and completion of necessary documentation.
- 99080 – Special Reports-more than the information conveyed in the usual medical communications or standard reporting form. This code should be used when the provider can complete the Department required H&P information from past records rather than a new examination.

Routine physicals such as pre-school, school, summer camp, Special Olympics or sports examinations for individuals up to the age of twenty-one (21) are covered with diagnosis V70.3 as long as one of above reasons is listed on claim form. The provider must use the Preventative Medicine procedure codes and diagnosis code **V20.1** or **V20.2** when billing for well physical exams.

3.2.6 Oral Surgeons

Oral surgeons who perform services in the hospital setting are required to bill CPT surgical codes on the CMS-1500 claim form using their physician/osteopath provider number.

Do not use CPT procedure code 41899, as this is an unspecified code and will cause delay in payment for services.

Extractions must be billed on an American Dental Association (ADA) claim form under the provider's dental provider number, with the appropriate CDT dental code and tooth number. Do not bill on a CMS-1500 Professional claim form for extractions.

3.3 Medical/Surgical Review

3.3.1 Overview

Medicaid contracts with a Quality Improvement Organization (QIO), formerly called a Peer Review Organization, to conduct review on a preadmission basis for selected diagnoses and procedures and a concurrent length of stay review on all hospital stays that exceed a specified number of days.

All inpatient admissions must be reviewed with the Department's QIO if the stay exceeds three days. If after a three day stay, the patient is not discharged by the next day (count day one of the admission as day one), a review must be obtained on or before day four, and thereafter at intervals determined by the QIO, Qualis Health. If the re-certification date falls on a weekend or holiday, follow the procedures detailed in Section XVII of the Qualis Health Provider Manual (www.qualishealth.org/medicaid.htm) or contact Qualis Health for detailed instructions.

Children in legal guardianship or legal custody of DHW are also subject to QIO review on a pre-admission basis and concurrent review for all hospital stays using the same criteria as for Medicaid clients.

QIO conducts one hundred percent pre-admission and concurrent review of all admissions to inpatient psychiatric facilities for Idaho Medicaid clients.

QIO performs retrospective reviews for services that were not reviewed in a timely manner (penalties may apply). Retrospective reviews may also be requested from the QIO for services requiring prior authorization and for admissions longer than three days when the patient receives retroactive eligibility. Refer to the Qualis Health Provider Manual, Section XV, for instructions.

The client's physician/osteopath or the treating facility may initiate the request for prior authorization. Both providers are equally responsible for obtaining authorization.

3.3.2 Penalties

Medicaid assesses a penalty to physicians/osteopaths and hospitals for failure to obtain a timely QIO review instead of withholding total payment. Information on the penalty amounts are detailed in the Rules Governing Medical Assistance per IDAPA 16.03.09.070 and IDAPA 16.03.09.079.12. Copies of the rules can be obtained on the web at:

<http://www2.state.id.us/adm/admrules/rules/idapa16/16index.htm>

under IDAPA 16.03.09 Medical Assistance or by calling the Department of Administration's Office of Administrative Rules in Boise, ID at (208) 332-1822

3.3.3 Prior Authorization

3.3.3.1 Prior Authorization Notification

If a service is approved, a prior authorization number is given to the provider requesting the approval either by a *Notice of Decision For Medical Services*

See **Section 2.3** for more information on electronically billing services that require prior authorization.

letter from Medicaid, or telephonically from Qualis Health. The prior authorization (PA) number must appear in the appropriate field on the physician/osteopath, hospital and, if applicable, assistant surgeon and anesthesiologist claim forms. It is not necessary to attach a copy of the prior authorization letter to a claim form. When billing electronically, more than one prior authorization number is allowed on the claim. Prior authorization numbers can be entered at both the header and detail level. Enter the PA number associated to the service detail in the appropriate field on the screen.

Note: providers billing services that require prior authorization on a paper form can only bill one authorization number per claim and the PA number must be indicated on the claim.

Lists of diagnosis and procedure codes that require prior authorization are found in **Sections 3.3.3.5, 3.3.3.6 and 3.3.3.7.**

3.3.3.2 Third Party Recovery

A client who is a Medicare/Medicaid client will only need to have prior authorization from the primary carrier, Medicare. Clients who have any other third party coverage, such as a private insurance company, private individual, corporation, or business, would still be subject to prior authorization review.

3.3.3.3 Healthy Connections

Healthy Connections clients require a referral from their primary care provider for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health prior authorization.

3.3.3.4 Quality Improvement Organization (QIO) Contact Information

To obtain a provider manual or for additional information regarding the review process, contact Qualis Health at:

Qualis Health
P O Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-9075

www.qualishealth.org/medicaid.htm

(800) 783-9207 Fax: (800) 826-3836

Monday through Friday (excluding holidays)
from 7:30 a.m. - 6:45 p.m. MST and 6:30 a.m. - 5:45 p.m. PST.

3.3.3.5 Quality Improvement Organization (QIO) Diagnosis Codes

Inpatient diagnoses requiring prior authorization for Idaho Medicaid and Division of Family and Children's Services (FACS) clients are:

Inpatient Psychiatric or Chemical Dependency Admissions (use fourth or fifth digit sub-classification): 291.0 through 314.0
Inpatient Physical Rehabilitation Admissions: V57 NOTE: This includes admission to all rehabilitation hospitals, regardless of the diagnosis on the claim.

3.3.3.6 Quality Improvement Organization (QIO) Procedure Codes

Inpatient and outpatient procedures requiring prior authorization for Idaho Medicaid and Division of Family and Children's Services clients are listed below.

Procedure	ICD-9-CM Code	CPT Code
Arthrodesis	78.59	22532, 22533, 22534 (effective 4/1/04)
	81.00 through 81.08	22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280
	81.30 through 81.39	
	81.61	
	81.62, 81.63, 81.64	
Unlisted neck, thorax procedure	78.41 (effective 4/1/04)	21899 (effective 4/1/04)
Unlisted spine procedure	78.71 (effective 4/1/04)	22899 (effective 4/1/04)
Hysterectomy	68.31, 68.39	58180, 59135, 59525
Abdominal	68.4	58150, 58152, 58200, 58951, 59135, 59525
	68.6	58210
	68.51	
Vaginal	68.59	58550, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294
		58953, 58954
Laparoscopic	68.7	
Radical	68.9	
Other and Unspecified		

Procedure	ICD-9-CM Code	CPT Code
Laminectomy/Diskectomy	03.02 03.09 03.1 03.6 80.50 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200
Reduction Mammoplasty Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement	81.51	27130
Total Hip Revision	81.53	27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125
Total Knee Replacement	81.54	27445, 27446, 27447
Total Knee Revision	81.55	27486, 27487
Transplants		
Transplant facilities must be Medicare approved		
Bone Marrow Transplant Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241
Bone Marrow Transplant Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240, 38242
Liver Transplant	50.59	47135, 47136
Kidney Transplant	55.61 55.69	50380 50360, 50365
Intestinal Transplant	46.97	44133, 44135, 44136
Heart Transplant	37.51, 37.52, 37.53, 37.54	33945
Alcohol and Drug Rehabilitation and Detoxification		
Inpatient Only		
Alcohol Rehabilitation	94.61	90899
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899

Procedure	ICD-9-CM Code	CPT Code
Psychiatric Admissions		
Diagnosis codes	291.0 through 314.0	Inpatient only
Physical Rehabilitation		
Care involving use of rehabilitation procedures. This includes admission to all rehabilitation facilities, regardless of diagnosis.	V57 (Diagnosis Code)	Inpatient only

3.3.3.7 Prior Authorization

Medicaid prior authorization is required for the following inpatient procedures:

- Reconstructive surgery not on the QIO list
- Plastic surgery not on the QIO list
- Cosmetic surgery not on the QIO list
- Elective surgery not on the QIO list
- Administratively Necessary (AN) days
- Excluded services found medically necessary in an EPSDT screen
- Genetic Pathology and Laboratory Testing

See **Section 2.3** for more information on billing services that require prior authorization.

If prior authorization is required, the prior authorization number must be indicated on the claim.

Send or fax requests for prior authorization and the required documentation to justify the medical necessity for these services to:

Division of Medicaid
Surgery Authorizations
PO Box 83720
Boise, ID 83720-0036

Fax (208) 364-1811

The following codes require a Medicaid prior authorization:

Proc	Description
03.29	Other chordotomy
15831	Excessive skin and subcutaneous tissue; abdomen
15877	Suction assisted lipectomy; trunk
17106	Destruction of cutaneous vascular proliferative lesions; less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions; 10.0 - 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions; over 50.0 sq cm
19324	Mammoplasty, augmentation w/o prosthetic implant
19325	Mammoplasty with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal, breast implant
19340	Immediate insertion of breast prosthesis
19342	Delayed insertion of breast prosthesis
19350	Reconstruction, nipple/areola
19357	Breast reconstruct w/tissue expander include subsequent expansion

Proc	Description
19361	Breast reconstruct w/ latissimus dorsi flap, w/wo prosthetic implant
19364	Breast reconstruction with free flap
19366 through 19371	Breast reconstruction
19380	Revision of reconstructed breast
19499	Unlisted procedure, breast
29999	Unlisted procedure, arthroscopy
30462	Rhinoplasty; tip, septum, osteotomies
36521	Therapeutic apheresis; with adsorption and plasma reinfusion
37700	Ligation & division of long saphenous vein at saphenofemoral junction
37720	Ligation, division & complete stripping of long or short saphenous veins
37730	Ligation, division & complete stripping of long and short saphenous veins
37735	Ligation, division & complete stripping of long or short saphenous
37760	Ligation of perforator veins, subfascial, radical
37780	Ligation & division of short saphenous vein
37785	Ligation, division and/or excision of recurrent or secondary varicose veins
38.59	Leg varicose veins ligation & stripping
43842	Gastric restrictive procedure-Medicare crossover only
43843	Gastroplasty, other than vert-banded, w/o bypass
43846	Gastric bypass, with roux-en-y gastroenterostomy
43847	Gastric procedure; w/bowel reconstruction
43850	Revision of gastroduodenal anastomosis w/reconstruction
44.31	High gastric bypass
44.39	Gastroenterostomy nec
48160	Pancreatectomy
50.51	Auxiliary liver transplant, leaving patients own liver in situ
52640	Resection, prostate
59866	Multifetal pregnancy reduction(s)
61885	Incision subcutaneous place cranial neurostimulator
64573	Incision for implant of neuro electrodes, cranial nerve
69930	Cochlear device implant; w/wo mastoidectomy
74799	Unlisted pulmonary procedure
85.53	Unilat breast implant
85.54	Bilateral breast implant
85.7	Total breast reconstruct
85.83	Breast full-thick graft
85.84	Breast pedicle graft
85.85	Breast muscle flap graft
85.87	Nipple repair nec
85.93	Breast implant revision
85.94	Breast implant removal
85.95	Insert breast tissue expander
85.96	Remove breast tissue expander
85.99	Breast operation nec
86.83	Size reduct plastic op, liposuction
87903	Phenotype analysis by DNA/RNA, HIV 1, first through 10 drugs tested
87904	Phenotype analysis by DNA/RNA, HIV1, each additional 1 through 5 drugs
88235	Tissue culture for chromosome analysis, amniotic
88267	Chromosome analysis, amniotic fluid

Proc	Description
88280	Chromosome analysis, amniotic fluid
97039	Unlisted modality; constant attendance
97139	Physical medicine treatment unlisted procedure
97799	Unlisted physical medicine service or procedure
99.99	Non-op procedure nec

Positron Emission Tomography (PET)

G0030-G0047; G0125; G0210-G0230; G0252-G0254; G0296

3.4 Consultations

3.4.1 Overview

A consultation is a type of service provided by a physician/osteopath whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician/osteopath or other appropriate practitioner of the healing arts. A physician/osteopath consultant may initiate diagnostic and therapeutic services.

The request for a consultation from the attending physician/osteopath or other appropriate practitioner and the need for the consultation must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting physician/osteopath or other appropriate source.

If a consultant subsequently assumes responsibility for management of a portion or all of the client's condition(s), the consultation codes should not be used. In the hospital setting, the physician/osteopath receiving the client for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established client code should be used.

3.5 Emergency Department/Critical Care Services

3.5.1 Overview

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled temporary services to clients who come in for immediate medical attention. The facility must be available 24-hours a day.

Idaho Medicaid pays hospitals for six emergency department visits per client in any calendar year. However, emergency department physician/osteopath services are covered beyond the six visits per year.

Use codes **99281-99285** to report evaluation and management services provided in the emergency department. No distinction is made between new and established clients in the emergency department.

3.5.2 Critical Care Services

Critical care includes the care of critically ill clients in a variety of medical emergencies that requires the constant attention of the physician/osteopath. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician/osteopath providing critical care:

- interpretation of cardiac output measurements
- chest x-rays
- blood gases, and information data stored in computers (e.g., ECG, blood pressure, hematologic data)
- gastric intubation
- temporary transcutaneous pacing
- ventilator management
- vascular access procedures

The critical care codes are used to report the total duration of time spent by a physician/osteopath providing constant attention to a critically ill client.

Use code **99291** for critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injuries or comatose client, requiring the prolonged presence of the physician/osteopath.

This code is used to report the first 30-74 minutes of critical care on a given day. **99291** is billed as one unit. It should be used only once per day even if the time spent by the physician/osteopath is not continuous on that day. **99291** is paid to only one physician/osteopath per day unless the client is transferred from one facility to another.

Use code **99292** to bill each additional 30 minutes of critical care. This code is used to report each additional 30 minutes beyond the first 74 minutes. Bill code **99292** in 30 minute units.

3.5.3 Other Procedures

Other procedures that are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

3.5.4 Prolonged Services

Use codes **99354-99357** when a physician/osteopath provides prolonged service involving direct (face-to-face) client contact that is beyond the usual service in an inpatient or outpatient setting.

Use code **99354 or 99356** to report the first 30-74 minute period of prolonged service on a given date, depending on the place of service. Prolonged service lasting less than 30 minutes on a given date is not separately reported, because the work involved is included in the evaluation and management codes.

Use code **99355 or 99357** to report each additional 30 minutes beyond the first 74 minutes, depending on the place of service. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

3.6 Laboratory Coverage

3.6.1 Physician/Osteopath Office Laboratories

Physician/osteopath office or group practice office laboratories must hold a current Clinical Laboratory Improvement Amendments (CLIA) certificate before Medicaid will reimburse for testing performed in the laboratory. Payments will be denied to any laboratory submitting claims for services not covered by a CLIA certificate and for claims for services rendered outside the effective dates of a CLIA certificate. Providers must have a current CLIA certificate on file with EDS.

Physicians/osteopaths can bill for clinical diagnostic laboratory services they personally performed or supervised.

Physician/osteopath performed or personally supervised diagnostic laboratory tests are reimbursed at the rate established by Medicaid.

Physician/osteopath owned laboratories cannot bill for tests sent to independent laboratories or pathology laboratories.

An office visit cannot be billed when a client comes in for a blood draw by a lab technician and does not see the doctor. The lab technician's cost is included in the lab procedure payment.

All genetic pathology procedures require prior authorization before services are rendered.

3.6.2 Independent Laboratories

Independent laboratories are not affiliated with a specific physician's/osteopath's office and have a separate provider number. They are able to do testing for multiple groups of physicians/osteopaths. Independent laboratories must bill Idaho Medicaid directly for the services they render.

3.6.3 Laboratory Procedures

Only the following CPT lab codes can be broken out into a professional and technical component:

- 88104 – 88125
- 88160 – 88162
- 88172 – 88173
- 88180 – 88182
- 88300 – 88319
- 88323
- 88331
- 88342 – 88365

In place of service **-21** (inpatient), **-22** (outpatient), and **-23** (emergency) the procedure codes should be billed with a **-26** modifier unless there is a procedure code that says "supervision and interpretation only." The hospital will bill for the technical component on their UB92 form.

If a pathologist has his own office and equipment, he may bill and be paid for the complete test including those that cannot be broken out into the professional and technical components.

3.6.4 Diagnostic Codes

A valid diagnosis code must always be indicated on the claim form. If the laboratory provider is unable to obtain the correct diagnosis, use diagnostic code **V72.6** as the primary diagnosis.

3.6.5 Venipuncture

Use procedure code **G0001** for routine veni-punctures and collection of specimens.

3.6.6 Presumptive Eligibility/Pregnant Woman and Children Services

Services rendered to clients who qualify for Medicaid under the Presumptive Eligible (PE) or Pregnant Woman and Children (PWC) programs must have a pregnancy diagnosis or documentation to substantiate how the service was pregnancy related. When in question, the laboratory provider should request a signed PWC medical necessity form from the referring physician/osteopath and attach the form to their claim.

3.6.7 Special Services

Handling and conveyance of specimens for transfer from the client to a place other than a physician's/osteopath's office/place of service **-12** (residence) or **-32** (nursing home) to a laboratory is covered by Medicaid when billed with procedure code **99001**.

3.6.8 EPSDT Blood Lead Screening

Federal mandate requires a screening for lead poisoning as a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and 24-months of age. In addition, children over the age of 24 month, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.

3.6.9 Modifiers

When a repeat procedure is ordered on the same day for the same client, report with modifier **91**. Modifier 90 is not currently accepted by the Idaho Medicaid program.

For more information on PE, PWC, and PWC Medical Necessity Forms, see **Section 1.3 General Provider and Client Information, Client Eligibility**

3.7 Ophthalmology Policy

3.7.1 Overview

Order all vision supplies (frames, lenses, contact lenses) from SWEEP Optical in Eugene, Oregon. Sweep Optical will bill Medicaid for the supplies. The optical provider bills Medicaid for the examination, a fitting or dispensing fee, and repairs when repair guidelines are met.

Contact SWEEP Optical at (800) 984-3204 for information on placing orders and ordering samples. Fax orders to (800) 383-1828.

Additional eye examinations may be paid in the following instance: when there is a documented visual correction needed that is equal to or greater than plus or minus .50 diopter per eye and/or reasonable medical justification.

Medicaid covers one complete visual examination annually to determine the need for eyeglasses to correct a refractive error. Eligible clients who have a diagnosis of visual defects, and need eyeglasses to correct a refractive error, can receive eyeglasses within the guidelines defined in this section.

While Medicare allows the use of evaluation and management codes for eye examinations, Medicaid requires the appropriate eye exam procedure code to be billed. Evaluation and management procedures are paid only for an eye injury or disease.

If the client requests, it is required that a copy of the prescription be provided to the client.



Submit eyeglass orders to the following address:

Sweep Optical
2145 Centennial Plaza
Eugene, OR 97401-2421



Phone: (800) 984-3204
Fax: (800) 383-1828



To see the complete catalog of frames and to place on-line orders, go to SWEEP Optical on the Web:

www.sweepoptical.com

3.7.2 Covered Services for Clients Under Age 21

Additional eye examinations and additional lenses may be paid for clients under age 21 when there is a documented visual correction needed that is equal to or greater than plus or minus .50 diopter per eye. If there is not a change equal to or greater than plus or minus .50 diopter per eye, a claim for an exam within one year of the previous examination will be denied.

An exception is the need for additional eye examinations and lenses when identified during an EPSDT screening visit. Prior authorization is required.



Submit prior authorization requests to:

Division of Medicaid
EPSDT Coordinator
Bureau of Care Management
P.O. Box 83720
Boise, ID 83720-0036

Fax: (208) 364-1864 Phone: (208) 364-1842

3.7.2.1 Repairs/Replacement for Clients Under Age 21

Prior authorization is not required for repair or replacement of lost glasses, broken or outgrown frames, or damaged or lost lenses for clients under the age of 21. If the broken frames can be repaired for less than the cost of the new frames, the frames should be repaired. If the repair costs are greater than the cost of new frames, new frames should be dispensed. However, the provider must justify, on the SWEEP order form, the reason for the service requested.

3.7.2.2 Frames and Lenses for Clients Under Age 21

Lenses are covered once every year. The exception to this rule is if the replacement criteria have been met. For information regarding the criteria for lens replacement see *Repairs/Replacement for Clients Under Age 21*.

Frames are covered once a year, **if needed**. For information regarding the replacement of frames see **Section 3.7.2.1, Repairs/Replacement for Clients Under Age 21**.

3.7.3 Covered Services for Clients Over Age 21

Medicaid will purchase eyeglasses for clients over 21 years of age and dispense one set of frames every four years.

3.7.3.1 Repairs/Replacement for Clients Over Age 21

Repairs on frames due to a manufacturer's defect are covered for one year. Repairs that involve the replacement of a temple or front must be submitted to SWEEP Optical for repair. Exceptions are:

- There is documentation in the client's record that the client cannot function safely without glasses for the time necessary to send the glasses to SWEEP for repairs; and
- The client does not have backup glasses to use while the broken glasses are being repaired.

3.7.3.2 Frames and Lenses for Clients Over Age 21

Medicaid may authorize new frames within the four-year period, when a physician/osteopath or optometrist documents a major change in visual acuity that cannot be accommodated in lenses that fit in the existing frame. Medicaid will not pay for broken, lost or missing frames or lenses for clients over 21 years of age within the four-year period.

Additional lenses may be covered when there is a documented visual correction change that is equal to or greater than plus or minus .5 diopters in one or both eyes (not a combined total correction of both eyes), or there has been a major add-on to the client's prescription such as the need for bifocals.

3.7.4 Covered Services for All Medicaid Clients

3.7.4.1 Dispensing/Fitting Fee

A dispensing fee may be billed when the client is eligible for new frames or lenses and they are ordered from SWEEP Optical. Third party resources do not pay for a dispensing or fitting fee. Dispensing fees may be billed to Medicaid without an insurance EOB or denial.

A dispensing fee may be billed for replacement glasses if a notation of the valid replacement is indicated on the claim. For more information, see *Covered Services for Clients Under Age 21*, and, *Frames and Lenses for Clients Over Age 21*.

3.7.4.2 Tinted, Photochromatic and Transition Lenses

Tinted, photochromatic, and transition lenses are only payable when determined to be medically necessary and prior authorized by the Department. Medicaid does not cover tinted lenses for cosmetic reasons. Clients who desire tinted prescription lenses may pay separately for tints, photochromatic or transition lenses. SWEEP Optical will bill the provider separately and the provider may bill the client their usual and customary charge for these options. When changes occur in the client's prescription, or the client cannot adapt, the client must pay for the additional charges.

3.7.4.3 Polycarbonate Lenses

Polycarbonate lenses are covered only when the correction required is above plus or minus 2.00 diopters per eye. Requests that meet this criterion may be ordered directly from SWEEP Optical by noting "Polycarbonate Lenses Requested" under Special Instructions on the SWEEP Optical Order Form. Requests for orders that do not meet the criteria will not be completed and must be prior authorized by the Department. Fax requests to (208) 364-1864 or mail to the address in **Section 3.7.4.6, Prior Authorization**.

3.7.4.4 Contact Lenses

Contact lenses will be payable only with a myopic condition requiring a correction equal to or greater than minus 4.00 diopter per eye, or when cataract surgery, keratoconus or other Medical condition as defined by the Department precludes the use of conventional lenses. Contact lenses and regular lenses prescribed in the same year are not payable by Medicaid. Prior authorization is required from the Department. Contacts are not covered for cosmetic or convenience purposes.

3.7.4.5 Bandage Lenses

Bandage lenses are covered with prior authorization from the Department for clients who have had cataract surgery.

3.7.4.6 Prior Authorization

Requests for prior authorization by the Department should include the client's name, Medicaid identification number, and a copy of the client's prescription.

PAs for eyeglasses, lenses, or contacts are only used by SWEEP Optical for billing Medicaid. Vision service providers must note the PA on the order to SWEEP Optical.

Fax the information to (208) 364-1864

or

Mail to: **Division of Medicaid**
Bureau of Care Management
P.O. Box 83720
Boise, ID 83720-0036

3.7.5 Exclusions

3.7.5.1 Eye Exercise Therapy

Medicaid does not pay for eye exercise therapy.

3.7.5.2 Trifocal and Progressive Lenses

Trifocal and progressive lenses are not covered but Medicaid will pay for the bifocal portion of the lenses. No-line (progressive) lenses are not covered and Medicaid does not cover the cost of remaking the lenses when a client cannot adapt to these lenses. Be sure clients are aware of this policy before placing the order. Clients who desire trifocal or progressive prescription lenses may pay separately for the difference between the usual and customary charge for bifocal lenses and the usual and customary charges for trifocal or progressive lenses. SWEEP Optical will bill the provider separately and the provider may bill the client their usual and customary charge.

3.7.6 Reimbursement

The lesser of the provider's usual and customary charge billed to the public or the Medicaid maximum allowable amount will be paid for each service rendered.

3.7.7 Attachments

Vision claims do not require attachments. Prior authorization numbers will be sent to the provider for reporting on the CMS-1500 claim form.

3.7.8 Refraction

When billing for a refraction, use procedure code **92015**. This service is allowed once every 365 days. Additional exams must be prior authorized by the Department. Procedure code **92015** includes specification of lens type, lens power, axis, prism, absorptive factor, impact resistance and other factors.

3.7.9 Third Party Recovery

See **Section 2, Third Party Recovery**, regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid for eye exams. See *Vision Provider Guidelines, Third Party Recovery (Section*

3.1.6), for information on frames and lens billing when the participant has a primary third party insurance.

3.7.10 Procedure Codes

Bill ophthalmology services using the appropriate five-digit Ophthalmology CPT codes. If more than one eye exam and evaluation per year is necessary due to diagnosis, it must be documented on the claim or with an attachment. Optometrists who have a provider agreement allowing payment for the treatment of injury or disease may also use the appropriate Evaluation and Management code from the CPT Manual. See the **NOTE** in **Section 3.7.1**.

3.7.10.1 Comprehensive Visual Examination

A comprehensive visual examination includes the following professional and technical ophthalmology services:

- History
- External and ophthalmoscopic examination
- Determination of best corrected visual acuity
- Gross visual fields
- Basic sensorimotor examination
- Refractive state

Do **not** itemize service components such as:

- Slit lamp examination
- Keratometry
- Ophthalmoscopy
- Retinoscopy
- Refractometry
- Tonometry
- Biomicroscopy
- Examination with cycloplegia

3.7.11 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS 1500 claim form. All vision and optician services are processed with the place of service code **11 — Office**.

3.8 Psychiatric Service Limits

3.8.1 Overview

Medicaid covers preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a psychiatrist in an inpatient or outpatient setting. A psychiatrist, billing for these services will use his/her own physician/osteopath provider number rather than the provider number from a mental health clinic, in which he may also be a participant.

3.8.2 Outpatient Psychiatric Care

Psychiatric evaluations are limited to 12 hours of evaluation in a calendar year. Psychotherapy services provided in either group or individual sessions are limited to 45 hours of treatment per calendar year (January to December).

3.8.3 Inpatient Psychiatric Care

There are no limitations to inpatient psychiatric care as long as the client is hospitalized in a general acute care hospital. The Department will pay for prior authorized medically necessary inpatient psychiatric hospital services in a free-standing psychiatric hospital (IMD) for clients under the age of twenty-one (21) who have a DSM IV diagnosis with substantial impairment in mood, perception or behavior. Admissions to freestanding psychiatric hospitals not contracted with DHW are not covered by Medicaid. OBRA 90 provides for psychiatric care for Medicaid coverage of hospital admissions with drug and alcohol related primary diagnoses. All admissions require a QIO Authorization, which includes review for less restrictive services by the Regional Mental Health Authority (RMHA). Refer to the Qualis Health Provider Manual, Section VIII for details. The provider manual may be found on the web at www.qualishealth.org/medicaid.htm or call Qualis Health at 800-783-9207.

See **Sections 1 and 3.3** for more on QIO.

For more information on mental health services, see the Clinic Guidelines **Section 3** on the Idaho Provider Handbook CD.

3.9 Obstetric Care

3.9.1 Overview

Medicaid covers total obstetrical care, including:

- Antepartum care
- Delivery
- Postpartum care

Obstetric care must be billed as a global charge unless the attending physician did not render all components of the care. Ante-partum care may be billed separately from the delivery and postpartum care only when the services were rendered by different group or billing physicians/osteopaths.

3.9.2 Total OB Care

Total OB care includes cesarean section or vaginal delivery, with or without episiotomy, with or without forceps or breech delivery.

Charges for total obstetric care must be billed after the delivery. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB clients. If the client is new to the office, a new client office visit code should be used. The initial examination must be identified as such and billed with the appropriate evaluation and management CPT code.

Prenatal diagnostic laboratory charges, such as a complete urinalysis, should be billed as separate charges using appropriate CPT codes. If an outside laboratory, not the clinic, did services the lab must bill Medicaid directly.

Resuscitation of the newborn infant is covered separately if billed under the child's name and MID number.

3.9.2.1 Place of Service Code

The place of service code for total obstetric care is normally **21 – inpatient**, and must be on the claim form in field 24B on the CMS-1500 form, and also in the electronic claim record.

3.9.3 Ante-partum Care

Ante-partum care includes the following usual prenatal services:

- Recording weight, blood pressure, fetal heart tones
- Routine dipstick urinalyses
- Maternity counseling

3.9.3.1 Billing for Incomplete Ante-partum Care

If the physician/osteopath sees the client for part of the prenatal care but does not deliver, submit charges only for the services delivered.

When billing for the initial physical examination and the second or third follow up visit, use the appropriate Evaluation and Management (E/M) CPT code.

Any laboratory services not previously submitted can be billed using the appropriate CPT procedure code. Do not bill for lab charges sent to an outside laboratory. Bill only for the services rendered.

When billing for four to six prenatal visits, use CPT code 59425 with the total charge for all visits on one line. Do not split-out each visit. Enter the first date of service in the “from date” field on the CMS-1500 claim form and the last date of service in the “to date” field. Note the date for each visit that falls between the “from date” of service and the “to date” of service on the CMS 1500 claim form.

When billing for seven or more prenatal visits with or without an initial visit, use CPT code 59426 with the total charge and the description “Antepartum Care Only” on one line with one charge. The “from date” of service should be the date of first prenatal visit and the “to date” of service should be the date of the last prenatal visit. These services would need to be split out to different claims when the client is not on the Healthy Connections program the entire time.

3.9.4 Postpartum Care

Postpartum care includes hospital and office visits in the 45-days following vaginal or cesarean section delivery. Postpartum care also includes contraceptive counseling.

3.9.4.1 Presumptive Eligibility/ Pregnant Women and Children Services

Medicaid extended eligibility to a larger number of pregnant women and made available new services to those eligible covered women during their pregnancy and postpartum period. The Presumptive Eligibility (PE) and the Pregnant Women and Children (PWC) programs are outlined in **Section 1, General Provider and Client Information, Presumptive Eligibility, and Pregnant Women and Children**. Please refer to Restricted Medical coverage under these sections for more information.

3.9.4.2 Billing PE Determinations

To bill for the completion of a PE determination follow these procedures:

- Use 9999999 as the client Medicaid ID number. Once the client's permanent Medicaid ID number appears on your Remittance and Status Report (RA), use the number on all future billings for that client. Continuing to use the ID number 9999999 may result in a delay in payment. Since this temporary number is assigned to all clients of PE, it is important to always indicate the client's social security number, date of birth and full name with any appropriate initials on the claim form or in the narrative field of an electronic claim
- Use HCPCS code **T1023** for the completion of PE determination.
- Include the client's full name and Social Security number.
- Include the client's date of birth.

The PE program covers only outpatient ambulatory pregnancy related services. A delivery cannot be billed under the Presumptive Eligibility program regardless of the setting.

See **Section 1.4** for more information on medical necessity.

Payment for the PE client appears on the Remittance Advice (RA) with the correct Medicaid Client Identification number and not the special billing number, 9999999, under which the claim was submitted.

3.9.4.3 Billing for PE or PWC Services

Claims submission for PW or PWC clients should follow the same billing practices as those for any pregnant Medicaid client. Services rendered must be a direct result of or directly affect the pregnancy.

Prenatal clinics can bill only the special services procedure codes and laboratory services under the prenatal clinic provider number.

3.9.4.4 Billing for Twin Deliveries

Delivery of first baby should be billed with the appropriate CPT code, 1 unit, and only the charges for the first delivery. Delivery of the second baby should be billed with a delivery code (**59409, 59514, 59612 or 59620**), modifier **51**, 1 unit, and only the charges for the second delivery. All antepartum or postpartum care should be included in the delivery code for the first baby.

3.9.4.5 Medical Necessity Form

The PE and PWC programs are for pregnancy-related services only. If the services rendered are not clearly pregnancy related, a Medical Necessity Form, which justifies how they are pregnancy related, must accompany the claim.

All services that are not clearly pregnancy related must have supporting documentation to justify the service. Each claim is reviewed on a case by case basis by the EDS Medical Consultant. If a claim is denied with an EOB code that states *"This PWC client's charge has been reviewed by the EDS Medical Consultant and denied,"* the provider may request further review from Medicaid.



Send appeals to:

Idaho Medicaid

Bureau of Benefits and Reimbursement Policy
P. O. Box 83720
Boise, ID 83720-0036

3.10 Abortions

3.10.1 Overview

Medicaid will cover a legal therapeutic abortion in order to save the life of the mother or in cases involving rape or incest.

Medicaid will pay in cases of rape or incest, as determined by a court or reported to a law enforcement agency. A copy of the court determination or documentation of the report to law enforcement may be attached to the claim to expedite payment. If the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional medical opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health. The certification must contain the name and address of the woman. When determination of the rape is based on age, the certification must show that the woman was under 18 at the time of the sexual intercourse.

When a pregnancy is life threatening, Medicaid will cover an abortion to save the life of the woman. Two licensed physicians or osteopaths must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. See **Section 3.10.4** for a sample of the certification that each physician or osteopath must complete.

3.10.2 Hospitalization

Hospital charges for a therapeutic abortion are subject to the same restrictions as the physician's/osteopath's charges. The physician/osteopath should send a copy of the properly completed Certification of Necessity form to the hospital with the client. The hospital is required to attach a copy of the form to their claim.

3.10.3 Exception

Medicaid does not pay for any type of abortion for clients on the Presumptive Eligibility (PE) program. Also, PE clients are not covered for any delivery services.

3.10.4 Sample Certification of Necessity for Abortions

I, _____ (name of physician/osteopath),
attending physician/osteopath to _____ (name of client)
certify that in my professional judgment, allowing this client's present
pregnancy to be carried to term will endanger her life.

Date _____

Signature of Physician/Osteopath _____

Name of client _____

Address of client _____

3.11 Hysterectomies

3.11.1 Overview

Medicaid only pays for hysterectomies if the following criteria are met:

- Substantiating documentation of medical necessity must be attached to the claim form.
- Rendering the client permanently incapable of reproducing was not the sole purpose of the surgery.
- Client was advised both verbally and in writing that the hysterectomy would result in permanent sterility and that she would no longer be able to bear children.
- The Authorization for Hysterectomy, or an equivalent authorizing form, must be signed by the client, regardless of the client's age or reproductive capabilities.
- Prior authorization is on file at EDS

The Authorization for Hysterectomy may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the client must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile. See **Section 3.11.2** for a sample Authorization for Hysterectomy form.

The Authorization for Hysterectomy must be on file at EDS before any claims can be paid.

Approval from the QIO, Qualis Health, must be obtained and the prior authorization number entered on the claim form in field 23 of the CMS 1500, or box 94 of the UB92.

The authorization and prior authorization must be on file at EDS before the claims for the surgeon, anesthesiologist, Hospital, or ASC can be paid. Outpatient hysterectomies are subject to Medicaid medical consultant review.

3.11.2 Sample Authorization for Hysterectomy Form

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Signature: _____

Date: _____

3.12 Family Planning Services

3.12.1 Overview

Family planning includes counseling and medical services prescribed or performed by an independent licensed physician/osteopath. Specific items covered are services for diagnosis, treatment, related counseling, and restricted sterilization.

3.12.2 Contraceptive Supplies

Medicaid will pay for contraceptive supplies including prescription diaphragms, intrauterine devices, implants, injections, contraceptive patches, and oral contraceptives.

3.12.3 Limitations

Payment for oral contraceptives is limited to the purchase of a three-month supply when purchased through a pharmacy.

Payment to providers of family planning services is limited to the Department's fee schedule.

Medicaid does not pay a physician's/osteopath's office for take-home contraceptives, except those inserted or fitted by the provider, such as an IUD, Norplant, or diaphragm.

3.12.4 Billing Information

Any services and/or supplies provided as part of a family planning visit should have the modifier **FP (family planning)** attached to the CPT/HCPCS code. See **Section 3.12.4.5 Family Planning Diagnoses/Modifier** for more information.

Supplies billed with J3490 *unclassified drug* require the NDC (National Drug Code), quantity dispensed, and basis of measure to be reported on the claim form. See **Section 3.18.6.3** for more information.

3.12.4.1 IUD

When billing for IUDs, use the following procedure codes (with modifier **FP**):

J7300 Intrauterine copper contraceptive

J7302 Mirena IUD

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

When billing J codes, the appropriate NDC must be billed with the procedure code. Medicaid pays for the IUD insertion, but does not cover any separate fees for the office exam. However, an office exam may be billed at the time of insertion if the client was treated for an unrelated diagnosis. Attach modifier **25** to the E/M CPT code.

3.12.4.2 Norplant

Norplant contraceptive services must be billed using the following procedure codes (with modifier **FP**):

11975 Insertion, implantable contraceptive capsules

- 11976** Removal, implantable contraceptive capsules
- 11977** Removal with reinsertion, implantable contraceptive capsules
- A4260** Levonorgestrel (contraceptive) implants system, including implants and supplies (Norplant kit)

3.12.4.3 Depo-Provera and Lunelle Injectionables

Depo-Provera and Lunelle injectionables must be billed using the following procedure codes(with modifier **FP**) :

- J1055** Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Depo-Provera)
- J1056** Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Lunelle)

When billing J codes, the appropriate NDC must be billed with the procedure codes. When Depo-Provera is used for any purpose other than contraception or for dosages up to 100 mg, use **J3490 unclassified drug** and indicate the NDC (National Drug Code), quantity dispensed, and units of measure. See Medicaid Information Release MA03-69 for more information.

3.12.4.4 Diaphragm

When billing for a diaphragm, use the following codes (with modifier **FP**):

- A4266** Diaphragm for contraceptive use
- 57170** Diaphragm or cervical cap fitting with instructions

3.12.4.5 Family Planning Diagnoses/Modifier

Any services provided as part of a family planning visit should include one of the diagnoses listed in the table below as the primary diagnosis. Attach modifier **FP** (*family planning*) to the CPT Evaluation and Management (E/M) code. Failure to report a family planning diagnosis and the CPT with the **FP** modifier, increases the direct cost of services to Idaho Medicaid, and will cause claims to deny if they do not include a Healthy Connections referral.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, insertions, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other unspecified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.13 Sterilization Procedures

3.13.1 Overview

Sterilizations (tubal ligations/vasectomies) do not require QIO approval; however, regulations concerning client information and consent require strict adherence.

3.13.2 Client Consent

The client must be at least 21 years of age at the time the consent form is signed and prior to performing the procedure.

The client must be mentally competent in order to give consent.

Thirty days must lapse between the time the client signs the consent form and the time the sterilization is performed. However, not more than 180 days can lapse after the client signs the consent and the procedure is performed. In other words, the time span looks like this:

- Day 1 Client signs form. This does not count as the first day.
- Day 2 Count begins; 30 days must lapse. This counts as the first day.
- Day 32 First day surgery can be performed.
- Day 180 Last day surgery can be performed.

The intent of the rules and the federal requirements that 30 days must elapse are to allow the client time to think about their decision. The physician/osteopath who does the surgery may not be the physician/osteopath who obtains the consent from the client. However, the physician/osteopath who performs the surgery must also sign a consent form, but the 30-day lapse need not be met again, as long as the client signed a consent form at least 31 days prior to surgery. If the client is on a restrictive program (PWC or PE) at time of delivery, the sterilization must be performed at that time to be covered.

3.13.3 Waiting Time Exceptions

If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the recipient's signature on the consent form. The surgeon must certify the following information in paragraph 2 of the physician's/osteopath's statement of the consent form:

- The expected delivery date and provide written details of the premature delivery.
- The emergency nature of the abdominal surgery in writing.
- Under no circumstance can the period between consent and sterilization exceed 180 days.

Failure to properly complete the physician's/osteopath's statement of the consent form will result in claim denial.

NOTE:

A valid consent form must be on file before hospital or anesthesiologist charges can be paid.

The only consent form for sterilizations that is authorized and accepted by Idaho Medicaid may be obtained by contacting EDS.

3.13.4 Interpreter Services

Suitable arrangements must be made to ensure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped.

An interpreter must be provided if the client does not understand either the language used on the consent form or spoken by the person obtaining the consent.

Providers may submit to Medicaid for reimbursement of interpreter services. Interpreters may not bill Medicaid directly for their services. Report procedure code **8296A** *Interpretive Services*, which encompasses all sign language or oral interpretive services regardless if the interpreter is certified, partially certified, non-certified, or is providing language services.

The interpreter certifies:

- The information and advice was accurately translated and verbally presented to the client.
- The consent form was read and accurately explained to the client.
- To the best of his or her knowledge and belief, the client understood the interpreter.

The interpreter must sign and date the consent form the same day the client's signature and date is obtained.

If the interpreter fails to complete the statement correctly, all claims regarding the sterilization, including physician/osteopath, hospital and anesthesiologist charges, will be denied. Medicaid will not accept corrected or altered consent forms. The providers of service may not bill the client if this error is made.

3.13.5 When Not to Obtain Consent

Informed consent must not be obtained while the client is in any of the following conditions:

- In labor or childbirth
- Seeking to obtain or obtaining an abortion
- Under the influence of alcohol or other mind altering substances

3.13.6 Signature Requirements

The client must voluntarily sign and date the consent form in the presence of the person obtaining the consent.

3.13.6.1 The Witness Certifies...

Before the client signs and dates the consent form, they were advised federal benefits would not be withheld regardless of their decision to be sterilized or not to be sterilized.

- The requirements on the consent form were verbally explained to the client.

- To the best of the witness' knowledge and belief, the client appeared mentally competent and knowingly and voluntarily consented to the sterilization.
- The person obtaining consent may sign the form anytime on or after the date the person giving consent signed the form. If the physician/osteopath obtains the client's signature, then the physician/osteopath must sign both statements on the form, once as the person obtaining the consent and again as the physician/osteopath performing the surgery.

If the person obtaining consent fails to complete the statement correctly, all claims regarding the sterilization, including physician/osteopath, hospital, and anesthesiologist charges, will be denied. Medicaid will not accept corrected or altered consent forms. Corrections to the client signature and signature date are not allowed. The providers of service may not bill the client if this error is made.

3.13.7 Physician's/Osteopath's Certification

The physician/osteopath must sign the consent form certifying that the requirements per the Rules Governing Medical Assistance, IDAPA 16.03.09.090.03, have been fulfilled. The signature of the physician/osteopath performing the sterilization must be obtained not more than three (3) days prior to surgery or any time after the surgery. A copy of the completed consent form must be submitted with the claim form.

3.14 Anesthesia Services

3.14.1 Overview

Medicaid accepts anesthesia codes from the anesthesia section of the Current Procedural Terminology (CPT) manual. Anesthesia claims must use the CPT anesthesia code that relates to the surgical procedure performed on the client.

Anesthesia time begins when the anesthesiologist physically starts to prepare the client for the induction of anesthesia in the operating room and ends when the anesthesiologist is no longer in constant attendance.

3.14.2 Billing Instructions

Enter the CPT anesthesia code for the surgical procedure that was performed on the client, total amount of time in minute increments, and any necessary modifiers from Section 3.14.3 *Modifiers*.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. A repeat anesthesia procedure on the same day which is billed with the Current Procedural Terminology (CPT) modifier 76 or 77 will be paid at \$0.00. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT anesthesia codes plus the total time for both sessions, with adequate documentation.

3.14.3 Modifiers

Up to three (3) modifiers may be used. Only use the modifiers in the table.

Modifier	Description
AA	Anesthesia services personally performed by an anesthesiologist. The -AA modifier is used for all basic procedures.
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures.
P1	Normal healthy patient
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life
P5	Moribund patient who is not expected to survive without the operation
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service (can be billed by CRNA or a physician/osteopath). This modifier for monitored anesthesia care (QS) is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service; with medical direction by a physician.
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service; without medical direction by a physician.

Modifier **22** should not be used with, or in place of, the appropriate modifier(s) when billing unless the services would require the use of more than three (3) of the modifiers listed above. Use the CPT anesthesia code

that most accurately describes the procedure performed. The use of modifier 22 overrides any other modifier indicated.

3.14.4 Epidural Billing

To bill for the epidural injections use procedure codes **62282** through **62311**.

3.14.4.1 Units

Enter total units (minutes) for time only in field 24G of the CMS-1500 claim form.

3.14.4.2 Diagnosis Code

Use code **999.9** if the procedure is due to an injury and **799.9** if not. The appropriate code must be used for abortions and D & C (dilation and curettage) procedures. Diagnosis code **V25.2** must be used for sterilizations. Enter the diagnosis code in field 21 of the CMS-1500 claim form.

3.15 Surgery Guidelines

3.15.1 Global Fee Concept

Medicaid pays all surgical fees based on the global fee concept. Global service includes:

- Examination of the client immediately before the surgery or upon admission to the hospital.
- Performance of the surgical procedure and in-hospital follow-up care.
- Follow-up visits in the office.

3.15.2 Complications

Complications are not considered part of a normal procedure and additional services for the treatment of complications should be billed accordingly.

Use appropriate CPT codes and modifiers for the billing of complications.

3.15.3 Modifiers

Modifiers are mandatory in certain circumstances. Refer to the CPT manual for specific guidance using modifiers.

In order to recognize assistant-at-surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed under the mid-level practitioner number with an **AS** modifier.

AS Physician Assistant or Nurse Practitioner services for assistant-at-surgery (*Medicare Part B bulletin GR00-3*)

3.15.4 Hospital Admissions

If the surgery is elective or non-trauma, the hospital admission is included in the fee for surgery. If the surgery is the result of an emergency or trauma situation, the hospital admission can be paid in addition to the surgery. Indicate in field 24I of the CMS-1500 claim form or in the electronic claim emergency indicator when the admission is trauma or emergency related.

3.16 Radiology Procedures

3.16.1 Overview

Radiology procedures are for those radiological services performed by or under the supervision of a physician/osteopath. Payment includes the professional component plus the technical component of the procedure. Services included are:

- Performance or supervision of the procedure
- Interpretation and writing of an examination report
- Consultation with referring physician/osteopath

3.16.2 Professional Component

The professional component represents services of the physician/osteopath (radiologist) to interpret and report on the procedure. To identify a charge for the professional component, use the appropriate five-digit CPT procedure code followed by modifier **-26**. This component is applicable in any situation in which the physician/osteopath does not provide the technical component as described below.

3.16.3 Exclusions

The professional component does not include the cost of personnel, material, space, equipment or other facilities.

3.16.4 Technical Component

The technical component includes charges for the following:

- Personnel
- Material, including usual contrast media and drugs
- Film or xerograph
- Space, equipment, and other facility charges

To identify a charge for the technical component, use the appropriate five-digit CPT procedure code followed by modifier **-TC**.

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to adequately price each claim.

3.16.5 Place-of-Service Codes

X-ray procedure codes billed in place of service **-21** (*inpatient*), **-22** (*outpatient*), or **-23** (*emergency*) should be billed with a **-26** modifier unless there is a procedure code with a description that says "supervision and interpretation only." If the procedure code description says: "supervision and interpretation only," use this code without the **-26** modifier since it is stating this is the professional component. The technical component (**-TC**) is billed by the facility that owns the equipment and must be included on the claim.

3.16.6 Place-of-Service (Office)

In place of service -11 (office), if the physician/osteopath owns the X-ray equipment, and also supervises and interprets the X-ray, the physician/osteopath may bill for the complete procedure using no modifier. If the physician/osteopath uses his/her equipment but sends the X-ray to a radiologist for interpretation, he/she must use the -**TC** modifier.

3.16.7 Diagnosis Codes

When billing for either the professional or technical component, the correct diagnosis code should be used. If the provider is unable to obtain the diagnosis from the primary physician/osteopath, it is acceptable to use **V72.5**, except for sterilizations or abortions.

3.17 Early and Periodic Screening, Diagnosis, and Treatment

3.17.1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program was designed to provide periodic screening of Medicaid eligible children for early detection of medical and developmental problems. The primary components of EPSDT are the medical screen, the developmental screen, and the dental screen. EPSDT screening codes can be used to bill for preschool, school, summer camp, Special Olympics, or sports physicals.

EPSDT services must be billed with the Preventative Medicine CPT codes, and if applicable, an EPSDT modifier (*see Section 3.17.4*).

3.17.2 Medical Screen Eligibility

All Medicaid eligible children ages birth through the last day of the month of their twenty-first (21) birthday are eligible for EPSDT screens. Parents periodically receive an informational letter reminding them the child is due to have an EPSDT screen.

Medicaid follows the American Academy of Pediatrics Periodicity Schedule. The screen must include the appropriate laboratory tests for that periodicity schedule. All EPSDT services are based on guidelines established by the Centers for Medicare and Medicaid Services. See **Section 1, General Provider and Client Information**, for the complete periodicity schedules.

3.17.3 Components of an EPSDT Screen

- History, including a comprehensive health and developmental history including assessment of both physical and mental health development.
- Physical exam: a comprehensive unclothed physical examination including a visual inspection of mouth and teeth.
- Laboratory: Federal mandate requires a screening for lead poisoning as a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and again at 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.
- Health education, including anticipatory guidance

See **Section 1.5.5.4, EPSDT Screening and Immunization Schedule**, for the complete schedule of age-appropriate health history and health screening services

3.17.4 EPSDT Modifiers

Old Modifier (not valid after Oct. 19, 2003)	Old Modifier Description	New Modifier (valid on or after Oct. 20, 2003)	New Modifier Description
RO	A problem is discovered and the EPSDT client is referred to another provider outside the Rural Health or Indian Health Clinic.	U6	Patient is referred to another provider.
ES	An EPSDT screening is done and no referral is made.	No replacement modifier	Not applicable
CI	A problem is discovered and the EPSDT client is treated by the EPSDT screener.	EP	Service provided as part of Medicaid EPSDT program
25	A client is seen for a medical condition and an EPSDT screen is performed.	25	(Description change only): Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

3.17.5 Diagnosis Codes

Use diagnosis code **V20.1** — Other Healthy Infant/Child, or **V20.2** — Routine Infant or Child Health Check for all EPSDT screening claims.

3.18 Other Billing Procedures

3.18.1 Foster Care

Program enrollment physicals for foster children are eligible for payment by Medicaid. See **Section 3.2.5.9**.

3.18.2 PKU Testing

Newborn Screening Kits (PKU) are a covered benefit of the Idaho Medicaid program. Test kits are ordered through the Idaho Newborn Screening Program and must be purchased in advance from:

Idaho Newborn Screening Program
450 West State Street, 4th floor
P O Box 83720
Boise, ID 83720-0036

Phone: (208) 334-4927

The price of the single kit is \$19.00 and \$38.00 for double kits. Please bill Medicaid in the following manner:

CMS-1500: use procedure code **S3620**

UB 92 (Hospitals only): Use revenue code 270

3.18.3 Collection Fees

Collection of a lab specimen for a client is not payable in an office setting.

3.18.4 Allergy Injections

Office calls are included in the reimbursement for allergy injections.

3.18.5 Immunizations

Most vaccines provided come through the Vaccines for Children (VFC) Program from the Department of Health and Welfare's Division of Health. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use.

When billing for a client who has both private insurance and Medicaid, bill the private insurance first using its billing instructions. After receiving the EOB from the primary insurance indicating partial or no payment, submit the EOB with the claim to Medicaid using the instructions below.

Medicaid should be billed for the administration of state-supplied vaccines according to the service(s) rendered at the time the vaccine was administered. Medicaid uses the most current version of the CPT (Current Procedural Terminology) guidelines.

Providers should bill their UCR (usual and customary rate) for administration of vaccines, provider-purchased vaccines, and Evaluation and Management (E/M) services.

The billing procedures for State-Supplied Vaccines and Provider-Purchased Vaccines are explained in the following subsections:

- State-supplied vaccines

- Administration of State-supplied vaccine with an evaluation and management (E/M) visit
- Administration of a provider-purchased childhood vaccine with or without an E/M visit
- Administration of a provider-purchased adult vaccine
- Administration of an injection that is part of a procedure
- Administration-only of a provider-purchased injectable/vaccine to a client with Medicare or other primary payer and Medicaid

3.18.5.1 State-supplied vaccines

When only a free vaccine(s) is administered, the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier SL billed at a zero dollar amount (\$0.00); and
- Administration code 90471 with modifier U7 (one unit only)

3.18.5.2 Administration of State-supplied Vaccine with Evaluation and Management (E/M) Visit

When a free vaccine(s) is administered in conjunction with an E/M visit, the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier SL billed at a zero dollar amount (\$0.00); and
- Administration code 90471 with modifier U7 (one unit only); and
- The appropriate CPT code for the E/M visit with modifier 25. In order to bill the E/M code, documentation in the client's record must reflect that additional services were rendered at the time the vaccine was given. If reporting the E/M visit with CPT 99201 or 99211, the administration (90471) is not separately billable but is considered inclusive within the E/M.

3.18.5.3 Administration of a Provider Purchased Childhood vaccine with or without an E/M visit.

This should only occur when a free vaccine is not available. Services provided should be billed at the UCR. When a provider-purchased childhood vaccine is administered to a child less than twenty-one (21) years old, the Medicaid claim must include the following information:

- The appropriate CPT or five-digit HCPCS code for the injectable vaccine; and
- Administration code 90471 for the first vaccine and 90472 for each additional vaccine, as appropriate
- And if applicable, the appropriate E/M code with modifier 25

In order to bill the E/M code, documentation in the client's record must reflect that additional services were rendered at the time the vaccine was given.

3.18.5.4 Administration of a Provider Purchased Adult Vaccine with or without an E/M Visit

When an injection or adult vaccine is administered in conjunction with an E/M visit, Medicaid will pay only for the E/M visit and the vaccine. The administration of the vaccine is inclusive within the E/M and is not separately billable. Services provided should be billed at the UCR. The Medicaid claim must include the following information:

- The appropriate CPT or five-digit HCPCS code for the injectable vaccine; and
- If applicable, the appropriate E/M CPT code billed at the UCR
- If administering a provider-purchased adult vaccine without an E/M visit, bill with the CPT/HCPCS for the vaccine and 90471 and/or 90472, as appropriate.

3.18.5.5 Administration of an Injection that is Part of a Procedure

When an injection is administered that is part of a procedure (i.e. allergy injections, therapeutic and diagnostic radiology, etc.) Medicaid will not pay the administration fee(s).

3.18.5.6 Administration Only of a Injectable/ Vaccine to a Client with Medicare or Other Primary Payer and Medicaid

When billing for a client who has either Medicare or private insurance, and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

Federal regulation requires that the provider who administers the medication must also bill for the cost of the medication. For example, a client may not purchase a prescription at a pharmacy (that bills Medicaid for the drug) and then take the medication to the physician's/osteopath's office to be administered (who also bills Medicaid for the administration fee). Also remember to bill Medicaid the usual and customary charge.

3.18.6 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to clients and providers who meet the criteria specifically identified in the Rules Governing Medical Assistance (IDAPA 16.03.09.128.). Providers must operate an American Diabetes Association (ADA) Recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a Recognized Program, a physician/osteopath's office, or outpatient hospital counseling. Counseling services must be billed under the provider number of their employer (i.e. the hospital, or physician/osteopath's clinic provider number).

3.18.6.1 Individual Counseling

To bill these services, use procedure code **G0108**, and bill in one-hour increments, to comply with Medicare billing instructions. Individual

counseling services must be face-to-face services between a CDE and the client. The CDE's services are to augment and not substitute for the services a physician/osteopath is expected to provide to diabetic clients. Medicaid allows 12 hours per client every five years for individual counseling.

3.18.6.2 Group Counseling

Group counseling is billed with procedure code **G0109** and is billed in one-hour increments to comply with Medicare billing instructions. Only hospitals operating an ADA Recognized Program may bill for group counseling. Medicaid allows 24 hours per client every five years for this service.

3.18.6.3 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS (Healthcare Common Procedure Coding System) codes for dates of service on or after February 1, 2004, must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each HCPCS medication. This requirement applies to cancer drugs with HCPCS codes, claims submitted electronically and on the paper CMS-1500 Form. This requirement **does not** apply to Medicare claims which "crossover" to Medicaid as the secondary payer.

The HCPCS medications that require NDC information are listed in the current HCPCS level II Expert Manual, Appendix 3, alphabetically by both generic, brand, trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB 628 – "NDC required"..

The collection of the NDC information will allow Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program. This requirement is supported by the federal Centers for Medicare and Medicaid Services (CMS), which encourages all states to develop systems to claim drug rebates due to the Medicaid programs. See State Medicaid Director Letter #03-002, at: <http://www.cms.hhs.gov/states/letters/smd031403.pdf>.

Electronic Claims

For professional providers that use the PES (Provider Electronic Solutions) billing software provided by EDS, new HIPAA compliant fields to report the NDC information are available as of February 1, 2004. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information (toll-free: (800) 685-3757 or (208) 383-4310 in the Boise area).

To enter NDC data in the PES software, complete the Service and RX tab fields using the following guidelines:

SERVICE Tabs:

- Step 1 Complete Service Tabs 1 and 2 as appropriate.
- Step 2 Select Service Tab 3 and complete the appropriate fields.
- Step 3 Enter "Y" in the RX Ind field to open the RX tab.

RX Tab:

- Step 1 Complete the following fields:

- NDCL: enter the 11 digit NDC number
- Prescription Number: not required.
- Units: enter the units dispensed. Refer to the HCPCS manual, Appendix 3, for brief directions regarding the "Amount" (Unit) column.
- Basis of Measurement: enter IU – International Units, GR – Grams, ML – Milliliters, or UN
- Unit Price: enter the price for the HCPCS medication dispensed

Refer to the PES (Provider Electronic Solution) handbook, Section 9 (837 Professional Forms) for more information on completing the Rx fields. It is available on the Idaho Medicaid Provider Resources CD and can be accessed online at: www2.state.id.us/dhw/medicaid/provhub/ipesh.f

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims

Submission of an *NDC Detail Attachment* is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the *NDC Detail Attachment* is available in the Forms Appendix and can be used as a master copy. The form can also be found on page 12 at: www2.state.id.us/dhw/medicaid/MedicAide/1003.pdf.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.19 Claim Form Billing

3.19.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

3.19.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

In addition to new HIPAA-required fields, the changes listed in Guidelines for Electronic Claims are effective October 20, 2003.

3.19.2.1 Guidelines for Electronic Claims

Detail lines

Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number

A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring providers' Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers

Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers

Up to **4** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes

Idaho Medicaid allows up to **8** diagnosis codes on an electronic HIPAA 837 Professional claim.

National Drug Code (NDC) information with HCPCS and CPT codes

A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See **Section 3.18.6.3** for more information.

Electronic crossovers

Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

See **Section 2** for more information on electronic billing.

3.19.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2003 is entered as 07/04/2003

3.19.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one prior authorization is allowed for paper claims.
- When billing a National Drug Code an NDC Detail Attachment must be filled out and sent with claim.

3.19.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.19.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable.	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable.	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's/osteopath's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's/osteopath's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Not required	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Not required	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an X .
24K	Reserved for Local Use	Desired	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.

Field	Field Name	Use	Directions
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.19.3.4 Sample Paper Claim Form

PLEASE
DO NOT
STAPLE
IN THIS
AREA

HEALTH INSURANCE CLAIM FORM														
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> </div> <div> <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) </div> </div>														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					11. INSURED'S POLICY GROUP OR FECA NUMBER					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										17a. I.D. NUMBER OF REFERRING PHYSICIAN				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										19. RESERVED FOR LOCAL USE				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____				
17a. I.D. NUMBER OF REFERRING PHYSICIAN										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										23. PRIOR AUTHORIZATION NUMBER				
19. RESERVED FOR LOCAL USE										24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE				
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										25. FEDERAL TAX I.D. NUMBER SSN EIN				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____										26. PATIENT'S ACCOUNT NO.				
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
23. PRIOR AUTHORIZATION NUMBER										28. TOTAL CHARGE \$				
24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE										29. AMOUNT PAID \$				
25. FEDERAL TAX I.D. NUMBER SSN EIN										30. BALANCE DUE \$				
26. PATIENT'S ACCOUNT NO.										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
28. TOTAL CHARGE \$										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500